ARIZONA MEDICAL BOARD

POSTGRADUATE TRAINING PERMIT APPLICATION

(Internship-Residency-Fellowship)

The Board shall grant a one year renewable training permit to a person participating in a teaching hospital's accredited internship, residency or clinical fellowship training program to allow that person to function only in the supervised setting of that program. If a person who is participating in a teaching hospital's accredited internship, residency or clinical fellowship program must repeat or make up time in the program due to resident progression or other issues, the Board may grant that person a training permit if requested to do so by the program's director of medical education or a person who holds an equivalent position. The individual must register with the Board for each year of training and pay the statutory nonrefundable **$50.00** registration fee.

The following information must be completed by the applicant and the licensed hospital which sponsors the accredited training program. If the applicant is applying for a short-term training permit of four months or less please also complete the Receiving Hospital Information. Please submit the application to the Arizona Medical Board, 9545 East Doubletree Ranch Road, Scottsdale, AZ 85258 at least **thirty days prior** to the initiation of the training.

1. Applicant Name:_____
(Last) (First) (Middle)

2. Current home address: _____
(Number and Street) (City) (State) (Zip)

3. Date of Birth: _____ _____
(Month, Day and Year) (City, State and Country of Birth)

4. Social Security Number: _____

5. Medical School Name: _____

Medical School Location: _____ Date of Graduation: _____
Month/Day/Year

6. If you graduated from a medical school located outside the United States of America or Canada please list below:

ECFMG #_____ Certificate Date: _____
Month/Day/Year

7. All States or provinces in which you have or had a license or registration. If more than two, attach separate listing. If license is pending or was not issued, so state. If none, please indicate by stating "Not Applicable."

(a)_____
(State Board) (License No.) (Status of License, i.e., expired, active, etc.)

(b)_____
(State Board) (License No.) (Status of License, i.e., expired, active, etc.)

8. List chronologically, all Internship, Residency and Fellowship training in U.S. or Canada (COMPLETED OR NOT), or Assistant Professorship (or higher) at any programs attended, showing institution, address, type of program and dates. Attach separate listing if needed.

INSTITUTION NAME	CITY/STATE	TYPE OF PROGRAM/PGY YEAR	DATES OF ATTENDANCE

9. Account for, in **chronological order**, all activities since graduation from medical school to present. ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.

10. Have you ever had any application for any professional license refused or denied by any licensing authority?	**YES ☐**	**NO ☐**
11. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?	**YES ☐**	**NO ☐**
12. Have you ever been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any medical school or post secondary educational program in which you were enrolled?	**YES ☐**	**NO ☐**
13. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently?	**YES ☐**	**NO ☐**
14. Have you ever voluntarily surrendered any healthcare license?	**YES ☐**	**NO ☐**
15. Have you ever had any healthcare license revoked?	**YES ☐**	**NO ☐**
16. Have you ever been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**YES ☐**	**NO ☐**
17. Have your privileges ever been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**YES ☐**	**NO ☐**
18. Has disciplinary action been taken against you by any licensing agency with regard to any professional license? Including but not limited to restricted, terminated, voluntarily or involuntarily resigned or withdrawn.	**YES ☐**	**NO ☐**
19. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**YES ☐**	**NO ☐**
20. Have you ever had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	**YES ☐**	**NO ☐**
21. Have you ever been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) **A "yes" answer is required even if you entered a diversion program.**	**YES ☐**	**NO ☐**
22. Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	**YES ☐**	**NO ☐**
23. In the last ten (10) years has a judgment or settlement been entered against you as a defendant in a medical malpractice suit? ***Please <u>do not</u> report <u>pending</u> malpractice suits or <u>settlements paid not related to a civil action</u>.**	**YES ☐**	**NO ☐**
24. Have you ever been court martialed or discharged other than honorably from the armed service?	**YES ☐**	**NO ☐**
25. Have you ever been terminated from a healthcare position with a city, county, or state government or the Federal government?	**YES ☐**	**NO ☐**
26. Have you ever been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	**YES ☐**	**NO ☐**

Note: ***<u>In the event the response to any of the questions numbered 10 through 26 is "YES"</u>*****, the applicant must file with the application a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such charge(s). IN ADDITION, the applicant must submit photocopies of any complaints, hearings, settlements or judgments together with copies of patient's hospital and/or office records to the AMB.**

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claim, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale & Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with Transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

CONFIDENTIAL
Physical/Mental Health and Substance Abuse

1. Within the last five years, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?	**YES ☐**	**NO ☐**
2. Are you now or have you in the last 5 years been addicted to or abused any chemical substance including alcohol (excluding tobacco and caffeine)?	**YES ☐**	**NO ☐**
3. Are you now being treated or have you in the last 5 years been treated or evaluated for a drug or alcohol addiction or participated in a rehabilitation program? ***If in a confidential program in another state see explanation below.**	**YES ☐**	**NO ☐**
4. Have you ever been criminally charged with or investigated by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility for inappropriate contact with a patient or patients?	**YES ☐**	**NO ☐**
5. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice? **See below for definition of ability to practice medicine**.	**YES ☐**	**NO ☐**

***In the event you answer YES to any of the above questions*, you must file with the application a detailed written narrative statement concerning the above matter(s), including the name and address of all training programs or healthcare providers, physicians, preceptors, hospitals/rehabilitation centers, etc. where you were counseled/treated. You must also have a copy of your history and physical examinations, consultation reports, discharge summaries from all hospitals/rehabilitation centers and a statement from your attending physicians or treating therapists setting forth your diagnosis, prognosis and recommendations for continuing care, treatment, supervision and a statement as to whether there is anything that would prevent you from safely practicing any type of medicine. This must be sent directly to the AMB.**

If you are currently participating or have participated pursuant to a CONFIDENTIAL AGREEMENT OR ORDER in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues YOU MUST SUBMIT A NARRATIVE OF CIRCUMSTANCES WITH YOUR APPLICATION AND REQUEST THE FOLLOWING DOCUMENTATION BE SENT DIRECTLY TO THE ARIZONA MEDICAL BOARD'S PHYSICIAN HEALTH PROGRAM.

- **Evaluation/Treatment records**
- **Psychiatric/Psychological records**
- **Compliance reports from state monitoring programs**

Please note: All documents requested above must be sent directly from the primary source to the Arizona Medical Board's Physician Health Program Department from the primary source and will not be accepted if submitted by the applicant.

FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION, INCLUDING REVOCATION OR DENIAL OF A PERMIT.

If you have any questions, please contact the Board's Physician Health Program at (480) 551-2716 or (877) 255-2212.

Ability to practice medicine is to be construed to include all of the following:

1. **The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;**
2. **The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and**
3. **The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.**

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to chronic and/or uncorrected orthopedic, visual, speech, or hearing impairments, epilepsy, multiple sclerosis, behavioral health illness, dementia, drug addiction and alcoholism.

The applicant_____

(PRINT OR TYPE YOUR NAME)

being first duly sworn upon his oath deposes and says: that I am the person herein named subscribing to this application; that I have read the statutes and rules regarding licensure and have read the complete application, know the full content thereof, and declare that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Arizona Medical Board or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Arizona Medical Board or its successors to release to the organizations, individuals or groups listed above any information which is material to the application or any subsequent licensure. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

Under penalty of perjury I certify I am a U.S. Citizen or a registered/qualified alien.

Signature of Applicant_____, M.D. Date _____

*** ARIZONA LAW REQUIRES AN APPLICANT WHO HAS BEEN CHARGED WITH A FELONY OR A MISDEMEANOR INVOLVING CONDUCT THAT MAY AFFECT PATIENT SAFETY AFTER SUBMITTING THE APPLICATION TO NOTIFY THE AMB WITHIN 10 DAYS AFTER THE CHARGE IS FILED. ARIZONA REVISED STATUTE (A.R.S.) §32-3208 (SEE WEBSITE UNDER *Physician Center – Reportable Misdemeanors* FOR LIST OF REPORTABLE MISDEMEANORS – ALL FELONIES ARE REPORTABLE.)**

HOSPITAL CERTIFICATION

Type of Program: Internship ☐ Residency ☐ Fellowship ☐

This is to certify that , _____ M.D., is currently engaged in a hospital training program in the field of _____ at (name of hospital) _____

The program COMMENCED on _____and the anticipated date of completion is_____ .

This specific request for permit is for the **dates** of _____through _____. I certify that the program is accredited by the ACGME, and certify that the answers to the following statements are true and correct:

If the answer to either question is <u>YES</u>, please attach a written explanation

1. Have any actions, restrictions, limitations (including probation or academic probation) been taken while the applicant was participating in any training program? Yes ☐ No ☐
2. Does the applicant have any disability which may affect his/her ability to safely engage in the practice of medicine? Yes ☐ No ☐

Signature _____ Title _____

Name Printed: _____

SEAL OF HOSPITAL

Date: _____

Should the postgraduate trainer be terminated from the program at any time, the facility must notify the Board immediately. Upon termination from the program, the postgraduate training permit holder no longer has valid credentials and may no longer practice medicine in Arizona. Should the facility wish to allow the postgraduate trainer to rejoin the program, a new application must be filed.

RECEIVING HOSPITAL CERTIFICATION

The board shall grant a training permit to a person who is not licensed in this state and who is participating in a short-term training program of four months or less conducted in an approved school of medicine or a hospital that has an accredited hospital internship, residency or clinical fellowship program in this state for the purpose of continuing medical education.

RECEIVING HOSPITAL CERTIFICATION FOR ROTATION DOCTORS
FOUR MONTHS OR LESS

Name of receiving hospital: _____

Address of receiving hospital:_____

Name Signed: _____

Name Printed: _____

Date of Rotation:_____ From:_____ To: _____

(For Official Use Only)

Arizona Medical Board: Permit Issued Date _____ Permit Number _____ Approved by _____

ARIZONA MEDICAL BOARD

PAYMENT CARD AUTHORIZATION
POSTGRADUATE TRAINING PERMIT FEE

Payment for: _____,M.D.

POSTGRADUATE TRAINING PERMIT FEE $50

Type of Card:☐ Visa ☐ MasterCard

Card #: ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Expiration Date: ☐☐-☐☐ **(MM-YY)**

Name as Shown on Payment Card: _____

Billing Address:
(Required)
Street Address: _____
City: _____ State: _____ Zip: _____

Phone Number of Cardholder: _____
(Required)

Mailing Address (If different from billing address)**:**

Street Address: _____
City: _____ State: _____ Zip: _____

Signature of Cardholder: _____ Date:_____

Please complete and return this form the *application* if paying by credit card.
This form and the application may be faxed to: 480-551-2704

If faxing this form, please do not mail the original as you may be charged twice.
OR
You may mail the form and all necessary documents to: Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258